Background
Proposed national health care reform initiatives include (1) expanding access to care by implementing changes to the private insurance market and expanding public coverage; (2) establishing Medicare payment incentive models such as medical homes, accountable care organizations (ACOs), and bundled payments, and (3) improving quality by conducting comparative effectiveness research, encouraging quality measurement and reporting, and supporting improvements in health information technology. The proposed national health care reforms will potentially expand rural veterans’ options for health insurance and thus affect whether veterans choose to receive health services through the Veterans Health Administration (VHA).

This policy brief addresses two questions:

1) How will the proposed national health care reforms affect rural veterans?

2) How will the proposed reforms affect the Veterans Health Administration (VHA)?

1. VHA’s unique role in U.S. health care

As of January 2009, all veterans who served on active duty in the armed forces are eligible to receive services through the VHA. Veterans with Service Connected (SC) conditions rated 50% or higher with incomes below the VHA means test or both receive care for free. Veterans receive free care for SC conditions less than 50%, and pay modest copayments for care not related to their SC conditions. Non-Service Connected veterans whose incomes fall above the VHA means test are also charged modest copayments.

The VHA serves as a model for publicly provided care in the United States. The VHA is unique and differs from other public programs in that it is

- both a direct care provider and a payer for health services,
- VHA providers are salaried employees, and
- VHA is a regionalized, hospital-centered health delivery system.

The VHA serves as a safety net for our nation’s veterans, and faces potentially significant adverse selection. The VHA patient population is characterized as less healthy, more disabled, elderly, and lower income than the general population, and having a high burden of mental illness and co-morbid, concomitant substance use disorder. Thus, the VHA is one of the largest mental health providers in the United States.
DEPARTMENT OF VETERANS AFFAIRS
Health Care Reform: Potential Implications for Rural Veterans and the Veterans Health Administration

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VHA Access to Care Issues

• While coverage of Priority 8 non-service connected low-income veterans has varied over time, currently all veterans are eligible to receive care regardless of SC status. VHA eligibility guidelines for Priority 8 veterans opened up in 1995, closed due to capacity constraints in January 2003, and reopened in January 2009.

• The VHA has been working to expand geographic access to care by opening up community based outpatient clinics (CBOCs) in rural areas since 1995.

• The majority of veterans enrolled in the VHA have another source of health care coverage. The Congressional Budget Office (CBO, 2009) recently reported that, overall, 79% of veterans enrolled in the VHA for fiscal year 2007 had some type of non-VHA coverage.

2. Proposed national health care reform initiatives include expanding access to care in both the private and public sectors of the health care market.

The Senate HELP Committee Affordable Health Choices Act and the House Tri-Committee America’s Affordable Health Choices Act of 2009 (Kaiser Foundation, 2009) include the following proposed health care reform initiatives:

• A mandate for individuals to have health insurance coverage, with a financial penalty for not having coverage.

• Premium subsidies for individuals based on a sliding scale and the federal poverty level guidelines.

• Employer requirements to offer coverage and contribute to premium costs, with small employer exemptions.

• Premium subsidies for small employers and employers covering 55- to 64-year-old retirees.

• Insurance pooling mechanisms such as a National Health Insurance Exchange. Under current debate is whether to include a public option or health insurance cooperatives.

• Changes to private insurance including requiring guarantee issue and renewability; prohibiting pre-existing condition exclusions; and limiting rating variation.

• Expansion of public programs (Medicaid, Children’s Health Insurance Plan).

Rural Challenges

The overall impact of national health care reforms is related to access and focuses on reducing the number of uninsured by increasing public and private health care coverage. Rural populations are currently more likely to be uninsured and under-insured (Lenardson et al., 2009). They are more likely to work for small-business employers or be self-employed, and thus have less access to employer-sponsored health insurance. Consequently, access reforms may have a greater impact on rural populations.

Potential Issues for Rural Veterans and the VHA

• Will VHA coverage “count” as coverage if all individuals are mandated to have health insurance coverage? Since Massachusetts implemented individual mandates and declared VHA as “creditable coverage” in July 2007, a precedent has been set to “count” VHA coverage.

• How will access reforms affect the availability and affordability of private coverage for rural veterans?

• How will other insurance options compare to the VHA in terms of benefits and out-of-pocket costs for rural veterans?

• How will access reforms affect the overall demand for VHA coverage?

• Will there be a continued demand for certain types of VHA services (e.g., mental health, prescription drugs)?

• Will the reforms have a different impact on rural veterans than on urban veterans (e.g., exemptions for small-business employers may result in rural veterans being less likely to have employer coverage than urban veterans)?

• If proposed reforms increase the percentage of rural veterans with both private coverage and VHA coverage, this will lead to a greater need to coordinate care between the VHA and the private sector.
3. Several payment incentive models, including patient-centered medical homes, accountable care organizations, and bundled payments, have been proposed as a means of improving care coordination, reducing costs, and improving quality in the Medicare program.

The patient-centered medical home is an approach to providing comprehensive primary care for children, youth, and adults. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association (2007) have adopted a joint set of principles to describe the characteristics of a medical home:

- Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation—the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals.
- Care is coordinated, integrated, or both across all elements of the complex health care system.
- Quality and safety are hallmarks of the medical home (e.g., evidence-based medicine, appropriate use of health information technology).
- Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Accountable Care Organizations (ACOs) are defined as a set of providers (hospital, primary care physicians, and specialists) responsible for the quality and cost of health care for a defined population of Medicare beneficiaries. Medical homes can be viewed as the “building blocks” for ACOs. The goal of ACOs is to constrain costs and improve quality. ACOs will require a formal organization and structure. MedPAC (2009) has suggested that ACOs could be formed from an integrated delivery system, physician-hospital organization, or academic medical center with a minimum of at least 5,000 patients.

Bundled payments would provide a fixed payment for a set of services (e.g., acute and post-acute care for pneumonia, stroke, hip fractures, heart failure and acute myocardial infarction). In theory, they should encourage smoother patient handoffs and better coordination of care, and may save money through negotiations across provider types and by choosing less expensive venues.

Rural Challenges

Demonstrations and pilot projects to test these payment incentive models have largely focused on urban areas and large integrated delivery systems. Their implementation in rural areas presents several challenges, including

- Achieving a sufficient patient volume for providers to assume risk; for example, for ACOs, a minimum patient base of 5,000 Medicare beneficiaries in thinly populated areas.
- Organizing providers that are not in integrated delivery systems into ACOs.
- Difficulty “virtually” integrating for bundled payments when rural patients receive hospital care and post-acute care in geographically dispersed facilities.
- Rural hospitals with few post-acute care options would be disadvantaged in negotiating for bundled payment contracts.
- Integrating payment incentives with cost-based reimbursement for critical access hospitals (CAHs).
- Ensuring fairness to areas with historically low costs.
- Financial vulnerability of rural and safety net providers.
- Changes in reimbursement structures may lead financially unstable rural providers to exit the market.
- Small-volume issues in measuring quality.
- Limited rural electronic health record (EHR) implementation.
Potential Issues for Rural Veterans and the VHA

The VHA has implemented initiatives to ensure that all patients have a primary care physician, including patients seen at CBOCs in rural areas. Implementation of these new payment-incentive models raises potential issues for rural veterans and the VHA, especially for veterans who receive care both from Medicare providers and the VHA system.

- When a patient receives care from both the private sector and VHA, who decides where the patient’s “medical home” should be, and how does the “medical home” coordinate care across the two entities?
- Similarly, which entity should be “accountable” for the cost and quality of care for patients with both Medicare and VHA coverage?
- VHA bills private insurance for services it provides, but cannot currently bill Medicare for VHA services. Will these payment models create incentives for Medicare providers to encourage shifting of care to the VHA?
- Merging of Medicare and VHA data is essential to understanding the full cost and quality of services provided to rural veterans with dual coverage.

4. Health care reform quality initiatives

The American Recovery and Reinvestment Act (ARRA) provides $1.1 billion to the National Institutes of Health, Agency for Health Care Research and Quality, and the Department of Health and Human Services to support comparative effectiveness research (CER). According to the Federal Coordinating Council for CER (2009), the purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, responding to their expressed needs about which interventions are most effective for which patients under specific circumstances. The Council has recommended uses of ARRA funds, including (1) investment in data infrastructure; (2) dissemination and translation of CER findings; and (3) CER focused on priority populations: racial and ethnic minorities, persons with disabilities, persons with multiple chronic conditions, elderly, and children.

Health care reform quality initiatives include expanded quality measurement, public reporting, and use of quality data in payment-Incentive models such as ACOs.

Rural Challenges

- Lack of clinical research in rural environments and limited participation of rural patients in clinical trials.
- Implementation of practice guidelines in rural settings often lags behind urban settings.
- Rural health professionals may have limited access to current evidence-based information, and rural patients have difficulty obtaining appropriate information to make health care decisions.
- Assessing rural relevance of quality measures and addressing small-volume problems in quality measurement.
- Measuring quality of episodes of care (across time and locations, especially for the chronically ill).
- Increasing public reporting of quality measures by CAHs.
- Improving CAH and rural hospital performance and reducing the gap with urban hospitals.

Potential Issues for Rural Veterans and the VHA

Several studies have documented better quality of care in VHA. The VHA scored higher than Medicare on 11 performance measures (Jha, 2003), and provides better care for diabetes (Kerr, 2004). VHA quality improvements are facilitated by extensive use of EHRs, the VHA’s performance measurement system, quality of care initiatives, and a strong sense of mission.

In light of the reforms, the renewed emphasis on improving quality raises the following issues for the VHA:
- Does quality vary within the VHA system, for example, between Veterans Affairs Medical Centers, CBOCs and across Veterans Integrated Service Networks, and if so, what key underlying factors are causing that variation?
- Similar rural challenges will apply to quality measurement in the VHA system (e.g., small-volume issues in rural CBOCs).
5. Meaningful Use of Health Information Technology (HIT)

HIT is a cornerstone of the Obama administration’s health care reform plans. The American Recovery and Reinvestment Act provides $19 billion to increase HIT adoption.

Rural Challenges

- Rural providers (including critical access hospitals and primary care practices) must implement “meaningful use” of EHRs by 2015 or face reimbursement reductions.
- Rural providers lag behind larger urban facilities in HIT adoption.
- The proposed “meaningful use” timeline needs to account for lags in adoption by smaller, rural physician practices and hospitals.

Potential Issues for Rural Veterans and the VHA

Although the VHA has used EHRs within the VHA system extensively for the past decade, a key challenge will be facilitating sharing of data from EHRs between the VHA and other provider systems and insurance platforms.

Summary

Health care reform initiatives affecting Medicare and the private sector have the potential to impact rural veterans and the VHA. The VHA should assess the potential impact of health care reform on rural veterans and develop a proactive strategy for responding to changes (e.g., care coordination, accountability for patients, and data sharing).

References


Additional Information

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